THE FOLLOWING VIOLATION(S) OF THE REGULATIONS OF CONNECTICUT STATE AGENCIES AND/OR CONNECTICUT GENERAL STATUTES WERE IDENTIFIED

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing Services (1) and/or (i) General (6) and/or CGS 19a-550.

1. *Based on clinical record review, interview and policy review for 1 of 3 patients (Patient #1) on the psychiatric unit, the facility failed to ensure that the patient was free from abuse and seclusion and/or that the staff person was removed from patient care when an allegation of abuse was identified. The findings include the following:

   a. Patient #1 was admitted to the hospital's in-patient behavioral health unit on 1/14/19 with diagnoses of schizoaffective, bipolar and borderline personality disorders. Review of the nurse's note dated 3/11/19 at 7:30 PM by RN #1 indicated that the patient was yelling at the nurse's station and was directed to his/her room. RN #1 notified the patient's nurse (RN #3) that the patient was not redirectable and suggested the patient receive as needed (PRN) medication. The note indicated that the patient was assisted to his/her feet by RN #1 and escorted to his/her room. The patient was placed in the room with the door closed and attempted to open door. The patient was redirected back into the room with the door closed. The patient opened the door again and motioned toward RN #1. RN #1 placed a hand on the patient's shoulder and directed the patient back into the room. The note indicated that the patient lowered self to floor and stated that RN #1 pushed patient.

      Review of hospital documentation of the incident identified that on 3/11/19, Patient #1 was yelling on the unit during report and RN #1 directed the patient to his/her room. The patient proceeded to the day room and RN #1 asked another RN to prepare an as needed (PRN) medication for the patient. RN #1 stated that he escorted the patient from the day room using CPI (Crisis Prevention Institute) techniques. He stated once in the room the patient attempted to leave the room.
      RN #1 placed a hand on the patient's back to guide the patient, and the patient placed his/herself on the floor in slow motion which RN #1 identified was "not an actual fall".

      Review of RN #2's statement identified that Patient #1 was yelling and he observed RN #1 place an open hand on the patient's back to escort the patient to his/her room. RN #2 stated that he went to the patient's room to assist and on arrival, RN #1 had the patient in his/her room with the door shut and was holding the door handle. RN #2 indicated that he could hear the patient talking through the door and the patient did not appear to be threatening or inappropriate.

      Interview with the Psychiatric Nursing Director on 6/5/19 at 10:30 AM identified that on 3/12/19 she and the Manager were notified of an incident the previous night (3/11/19). On review of video of the incident, RN #1 was observed placing his hands on Patient #1, pick the patient up from a chair, place his hands on his/her shoulders and escorting the

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patient down the hall. The Nursing Director indicated that picking up a patient is against CPI training.

Review of the hospital's video monitoring on 6/5/19 at 2:00 PM identified that on 3/11/19 RN #1 was observed walking the patient to his/her room, pushing the patient into the room, closing the patient's room door and holding the door closed for a brief period which is inappropriate seclusion of a patient. The video further indicated that when the door was opened by RN #1, the patient walked towards the door slowly with hands raised and as he/she got closer to the door, RN #1 raised his hand, placed it on the patient's left shoulder and pushed the patient back, causing the patient to stumble.

The facility failed to ensure that the patient was free from abuse and seclusion.

Review of the Rules of Conduct policy indicated that violations of the rules of conduct are in part unprofessional or inappropriate behavior, threatening, intimidating or coercing patients, and visitors at any time.

b. Interview with the Clinical Resource Leader (CRL) on 6/5/19 at 11:15 AM indicated that on 3/11/19 when she arrived to the unit at approximately 7:00 PM Patient #1 informed her that RN #1 had pushed him/her. The CRL indicated that she and RN #3 assessed the patient and no injuries were noted. Patient #1 denied injuries however was upset and angry. The CRL indicated that she spoke with RN #1 who denied pushing the patient but felt like the video would look like he did. The CRL remained on the unit throughout the night and stated that she did not feel that RN #1 was a danger to patients. The CRL stated that she did call to see if she could view the video but did not have access.

Interview with the Nursing Director on 6/5/19 at 10:30 AM indicated that she was notified of the incident on 3/12/19 in the morning and reviewed the video of the incident. Based on the review RN #1 was suspended with pay and subsequently terminated on 3/18/19 based on lifting the patient out of a chair, inappropriate seclusion and pushing the patient.

Subsequent to the event staff were reeducated starting on 3/12/19 on proper technique for CPI escorting and therapeutic holds and reeducated on seclusion and chain of command. Restraint and seclusion education, related topics and audits were added to Daily huddles and are on-going.

The facility failed to ensure that RN #1 was removed from patient care when an allegation of abuse was identified.

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2. *Based on clinical record review, interview and policy review for 1 of 3 patients (Patient #1) the facility failed to ensure that a patient was placed in seclusion based on a physician's order. The findings include the following:

   a. Patient #1 was admitted to the hospital's in-patient behavioral health unit on 1/14/19 with diagnoses of schizoaffective, bipolar and borderline personality disorders. Review of the nurse's note dated 3/11/19 at 7:30 PM by RN #1 indicated that the patient was yelling at the nurse's station and was directed to his/her room. RN #1 notified the patient's nurse (RN #3) that the patient was not redirectable and suggested the patient receive as needed (PRN) medication. The note indicated that the patient was assisted to his/her feet by RN #1 and escorted to his/her room. The patient was placed in the room with the door closed and attempted to open door. The patient was redirected back into the room with the door closed. The patient opened the door again and motioned toward RN #1. RN #1 placed a hand on the patient's shoulder and directed the patient back into the room. The note indicated that the patient lowered self to floor and stated that RN #1 pushed patient.

   Review of hospital documentation of the incident identified that on 3/11/19, Patient #1 was yelling on the unit during report and RN #1 directed the patient to his/her room. The patient proceeded to the day room and RN #1 asked another RN to prepare an as needed (PRN) medication for the patient. RN #1 stated that he escorted the patient from the day room using CPI (Crisis Prevention Institute) techniques. He stated once in the room the patient attempted to leave the room. RN #1 placed a hand on the patient's back to guide the patient, and the patient motion placed his/herself on the floor in slow which was "not an actual fall".

   Review of RN #2's statement identified that Patient #1 was yelling and he observed RN #1 place an open hand on the patient's back to escort the patient to his/her room. RN #2 stated that he went to the patient's room to assist and on arrival, RN #1 had the patient in his/her room with the door shut and was holding the door handle. RN #2 indicated that he could hear the patient talking through the door and the patient did not appear to be threatening or inappropriate.

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Subsequent to the event staff were reeducated starting on 3/12/19 on proper technique for CPI escorting and therapeutic holds and reeducated on seclusion and chain of command. Restraint and seclusion education, related topics and audits were added to Daily huddles and are on-going.

Review of Restraint and Seclusion policy indicated that seclusion should be initiated if alternatives are unsuccessful, and based on a provider order. When a patient is in seclusion the patient is to be monitored constantly with the patient in the direct field of vision.

The following is a violation of the Regulation of Connecticut State Agencies Section 19-13-D3 (e) Nursing Services (1) and/or (i) General (6).

3. Based on clinical record review, interview and policy review for one patient (Patient #1) the facility failed to ensure that a physical assessment was documented in the clinical record. The findings include the following:

Patient #1 was admitted to the facility on 1/14/19 with diagnosis of schizoaffective disorder, bipolar and borderline personality. Review of the nurse's note dated 3/11/19 at 7:30 PM by RN #1 indicated

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that the patient was yelling at the nurse's station and was directed to his/her room.

Review of hospital documentation of an incident identified that on 3/11/19, Patient #1 was yelling on the unit during report and RN #1 directed the patient to his/her room. RN #1 placed a hand on the patient's back to guide the patient, and the patient placed his/herself on the floor in slow motion which RN #1 identified was "not an actual fall".

Interview with the Clinical Resource Leader (CRL) on 6/5/19 at 11:15 AM indicated that on 3/11/19 when she arrived to the unit at approximately 7:00 PM Patient #1 informed her that RN #1 had pushed him/her. The CRL indicated that she and RN #3 assessed the patient and no injuries were noted. Patient #1 denied injuries however was upset and angry.

The clinical record failed to identify an assessment of the patient following an allegation of being pushed by staff.

Hartford HealthCare
Connect to healthier.

Hospital of Central Connecticut
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New Britain, CT 06050
860.224.5270 - Phone
860.224.5787 - Fax

Facsimile Cover Sheet

PHONE/FAX: 860-509-8018 / 860-509-7535

TO: Sue Newton, Supervisor; Adverse Events

COMPANY: Department of Public Health

FROM:	**Quality and Safety Management – Linda Stuermer**
PHONE/FAX:	**860.224.5262/860.224.5787**
DATE:	**July 18,2019**

RE: Corrective Action Plan for Visit of 6/5/2019

Pages: 23

Hospital of Central Connecticut

DPH Corrective Action Plan

In response to DPH's Investigation Visit initiated on 6/5/2019

The investigated incident occurred on 3/11-3/12 on the inpatient Behavioral Health Unit EW3.

Issue: An allegation of abuse was made by a patient on the Behavioral Health Unit (BHU). The RN in question was told by the Clinical Resource Leader (CRL) not to have any contact with the patient who made the accusation and was allowed to work the remainder of the shift. The Director of Behavioral Health Services was contacted in the morning placed the RN in question on paid administrative leave pending investigation. The patient who made the accusation was secluded in her room without a physician's order.
The patient reported that she fell in her room during this episode and was assessed post fall by two RN's but there was no documentation of the assessment in the electronic medical record.

Corrective Actions with Completion Dates:

1. Following the incident on 3/11/19 the HRO safety behavior of "ARCC" was discussed with staff at daily lean huddles starting the following morning on 3/12/19 regarding accusations of abuse/assault and notifying Leadership immediately. This was also placed on the Lean Safety Board. Standard work has been developed regarding guidelines to follow when a patient accuses a staff member of abuse or assault or patient abuse or assault is witnessed by a staff member. The standard work clearly states that the accused staff member will immediately be removed from patient care and the patient care area; the charge nurse will contact the Director of Behavioral Health, Manager of Behavioral Health or the Nursing Supervisor for direction. The Director, Manager or Nursing Supervisor will instruct the charge RN that the accused staff member will either be removed from patient care and all patient care areas pending investigation of the allegation or, at the Manager, Director or Supervisors discretion and depending on the situation instruct that the staff member is to be sent home pending further investigation of the allegation. An SBAR was sent to all BH staff regarding standard work/new guidelines for accusations of patient abuse or assault on 7/17/19 with the standard work flow sheet attached. In addition a copy of the SBAR and the standard work flow sheet was placed in the shift report book for a read and sign by all staff to ensure that all staff have read and understand the guidelines. This will be reviewed at change of shift report. Due to many staff being on vacation at this time of year the projected completion date is 8/16/19. Any outliers will be tracked by management and contacted individually upon their return. The Director, Manager or RN Supervisor will call, text or email the Director of HR regarding the incident and actions that have been taken. The MD on call will be notified and a request for the hospitalist to come to assess and document patient for injury will be made.

2. Following the incident on 3/11/19, the incident was reviewed at daily lean huddles as an illustration of improper use of Seclusion and was added to the "learning moment" portion of the board. An SBAR was sent to all staff on 7/17/19 regarding the appropriate use of seclusion which included a copy of the Restraint and Seclusion Policy for review. In addition a copy of the SBAR and the Restraint and Seclusion Policy was placed in the shift report book for a read and sign by all staff to ensure that all staff have read and understand the guidelines. This will be reviewed at change of shift report. Due to many staff being on vacation at this time of year the projected

completion date is 8/16/19. Any outliers will be tracked by management and contacted individually upon their return. The CRL and or Charge Nurse will monitor all Seclusion episodes in real time as to ensure proper use of Seclusion. Staff will be coached and mentored in real time as needed.

3. All BH Nursing staff are being re-educated on proper documentation of post fall assessment. An SBAR was sent on 7/17/19 regarding required documentation of the post-fall assessment by the RN which included a copy of the Fall Prevention and Management HHC policy for review. In addition a copy of the SBAR and the Restraint and Seclusion Policy was placed in the shift report book for a read and sign by all staff to ensure that all staff have read and understand the guidelines. This will be reviewed at change of shift report. Due to many staff being on vacation at this time of year the projected completion date is 8/16/19. Any outliers will be tracked by management and contacted individually upon their return.

Monitoring Plan:

Behavioral Health Management will track and document all accusations of patient abuse/neglect and subsequent investigations. During the investigation if it is found that standard work was not followed the employee/s will be coached and mentored and just culture will be applied.

The CRL will complete an audit sheet on all seclusion episodes on a daily basis. Non-compliance will be addressed in real time and the results will be reported to the Clinical Nurse Manager and Director of BH Services on a weekly basis.

The Quality Department will audit all falls that occur on the BHU to ensure that a post fall assessment is documented by the RN. Any omissions will be sent to both the RN and the Manager of the BHU for follow up. The audit will be performed until 90% or better compliance is achieved for a period of three consecutive months.

Responsible Person:

The Director of Behavioral Health Services will be responsible for ensuring compliance with this plan of correction.

Hartford HealthCare

Standard Work- Patient allegation of abuse by staff member

Hospital of Central Connecticut, Behavioral Health Services, EW3 and Acute Behavioral Health Unit (ABU)

HW (New Hartford HealthCare Works)

Process Information					
Process Description	Follow up steps when a patient accuses a staff member of abuse/assault, witnessed patient abuse/assault by a staff member				
Goal	Maintian safe environment for both patients and staff	Process Boundaries			
Staff	All staff	Total Cycle Time			
Notes	1	Process begins when a patient alleges or is witnessed to be assaulted/abused by a staff member			
	2				
	3				

Steps	Role	Task Description	Systems/Tools	Cycle Time (min)	Standard Work Observations
		Start Process			✚ ✓ ▲
1	Any staff	Identifies the allegation of abuse/assault OR witnesses a staff member with abusive/assaultive behavior towards a patient	None	1 min	
2	Any staff	Immediately notifies the Charge RN of the allegetion/incident	None	3 min	
3	Charge RN	Immediately asks the accused staff member to stop patient care and wait in break room until leadership can be contacted	none	1 min	
5	Charge RN	Calls manager/director/RN supervisor to notify of the event	phone	5 mins	
6	Manager/Director/Supervisor	Call/text/email sent to Director of HR regarding incident. Manager/Director/Supervisor will advise charge RN that staff member is to remain out of patient care areas and is to have no contact with patients pending investigation or they may, at their discretion and dependant on the situation, instruct that staff member will be sent home pending investigation. Alternative assignments for patient care will be identified with the Charge RN.	none	15 mins	
7	Charge RN	Contact MD on call to notify, request hospitalist come to assess and document patient for injury	phone/EMR	20 mins	
Version Date	7/17/2019	End Process	Total Cycle Time: Minutes	45 mins	